STATEMENT

By

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BEFORE THE

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COMMITTEE ON HEALTH

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Thank you Chairman Underheim, and members of the Assembly Committee on Health, for allowing me to speak today on the subject of health care costs. I am Dr. Fred Wesbrook. I am a general internal medicine physician, and I am President of Marshfield Clinic. I would like to briefly describe Marshfield Clinic. Then I would like to opine on the rising costs of medical care in Wisconsin and what should be done to address their root causes.

Marshfield Clinic is one of the largest group medical practices in the country, currently comprised of 690 physicians in 86 specialties, and 5,400 additional staff, disbursed among 42 clinical centers in 32 communities in northern, central and western Wisconsin. We see patients from every county of the state, from every state in the nation, and from 26 foreign countries. Our annual patient visits number 1.6 million.

Marshfield Clinic's mission is to serve patients through accessible, high quality health care, research and education. The Clinic is operated as a charitable organization with all Clinic assets held in a charitable trust. Our research foundation is the largest private medical research facility in the State, currently conducting hundreds of medical research studies and contributing over 100 scientific papers annually to the peer-reviewed scientific literature. Our graduate medical education program, in conjunction with Saint Joseph's Hospital and the University of Wisconsin, trains graduate physicians in the specialties of internal medicine, pediatrics, combined medicine-pediatrics, general surgery, and dermatology. The Clinic is the sole sponsor of Security Health Plan of Wisconsin, Inc., a not-for-profit HMO that insures 120,000 people. We believe ourselves

to be a state-of-the art health care system, and we believe Marshfield Clinic to be among the health industry's leaders in integrated rural health delivery, computerized medical records, farm health and safety, epidemiology, areas of medical genetics, food safety, and population health initiatives such as improving immunization rates, and working with communities to improve general health.

Marshfield Clinic partners with a federally funded Community Health Center to serve eligible uninsured and underinsured people. We partner with the State on BadgerCare. When patients who are not eligible for these and other programs come to us with no means to pay, we take care of them anyway. We limit neither access nor treatment to any patient based on their ability to pay.

We are alarmed by the rising costs of care, the growing number of people who cannot afford health care, and the increasing frustration and dissatisfaction of the public relative to the health care system. We, like everyone else, hope for a health care system that can be relied upon to uniformly provide safe, effective, affordable care for ourselves, for our children and for our grandchildren, no matter where they may live, regardless of who may or may not employ them, and regardless of their age, gender, ethnicity, belief system, or socio-economic status.

That is not the case today. Today's health care system is more properly characterized as a "non-system." Overall, it is delivering exactly what one would expect from a product or service whose components were designed over decades by hundreds of thousands of different people without specifications, without an overall plan, and

without the requirement that the various elements should fit together effectively into an integrated whole. There is huge variation at every level-variation in expectations, accessibility, treatment methods, utilization, record keeping, insurance coverage, payment rules, regulations, population demographics, etc., etc. The medical industry is at least a decade behind the rest of American industry in the applications of computer science, and only large medical organizations can even begin to afford the sophisticated computer systems necessary to support electronic records, decision support and outcomes analysis. The nation's medical schools are not training the mix of physician specialists that the country needs. The specialty mix is instead driven by a reimbursement system that disproportionately rewards costly interventional procedures over preventive care. Indeed, the reimbursement system, which is predominately oriented to episodes of care instead of the continuum of care, actually creates obstacles to cost effective behavior. For example, Medicare will not pay thousands of dollars for the home administration of some antibiotics, but it will pay tens of thousands to have the same patient admitted to a nursing home for the identical treatment. There is little support to apply proven methods to standardize to the best cost-effective practices, otherwise known as disease state management systems. For example, Marshfield Clinic's Dr. Michael Hillman testified in Washington in April to the Health Subcommittee of the Committee on Ways and Means regarding disease state management for patients who require chronic anticoagulation. Between 7% and 10% of these patients can be expected to require expensive hospitalization for complications of treatment. With a standardized protocol for patient education and nurse monitoring and follow up, we reduced the to fewer than 2% in the managed population. If this system were applied to all anticoagulated Medicare patients in our service area, Medicare could avoid

$28,000,000 annually in hospital costs. However, Medicare has no mechanism to reimburse the $3,000,000 that it would cost Marshfield Clinic, or anyone else, to implement such a program.

The Assembly Committee on Health has already heard about some of these things, and you have also heard about the costs of technological advances, defensive medicine, tort reform, legislative mandates, drug costs, Medicare's billion dollar underpayment to Wisconsin and the impact of shifting those costs to the private sector, and so forth.

The thought I would like to offer is this. All of these issues are interconnected. Few, if any, are isolated problems. Few, if any can be fixed quickly; and none of the fixes will be durable unless done in the context of the overall health care system. We need, as a state and as a nation, to reach agreement on the nature and causes of the problems; and then, more importantly, so that we can all align our efforts, we need to subscribe to a common vision or plan for what the future health system ought to be and how it ought to work. Only then can the industry rationally undertake to execute the well-known formula to reduce costs and improve quality. The formula is: 1) Standardize everything to the best-proved method; and 2) Continuously decrease waste in the system. A guiding future vision already exists, and it is waiting for subscribers.

The National Academy of Sciences was chartered by Congress in 1863 to advise the federal government on scientific and technical matters. The Institute of Medicine, established in 1970, is the branch of the Academy that advises on matters pertaining to the health of the public. The general public first became widely aware of the Institute of

Medicine in 1999, when it published its now famous report, *To Err is Human: Building a Safer Health System*. This report, as we all now know, brought to light the extent of medical mistakes and safety issues, and its recommendations are being quoted and pursued across the nation, particularly with respect to computerized systems to prevent medication prescribing errors.

In the Spring of 2001, the Institute of Medicine published its far more comprehensive report on the quality of health care today, entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report in one way or another addresses virtually everything under discussion here today. It is critical of today's healthcare system as inconsistent, highly inefficient, and largely failing at translating available knowledge into practice. It states that the American healthcare system is in need of fundamental change, and that Americans frequently cannot count on receiving care that meets their needs and care that is based on the best scientific knowledge available. The IOM offers the vision of a system transformed into one that is: 1) Safe (avoiding injuries to patients from care intended to help them); 2) Effective (services based on scientific knowledge, and refraining from providing services of little or no benefit); 3) Patient-centered (respectful of and responsive to individual patient preferences); 4) Timely (reducing harmful waits and delays); 5) Efficient (avoiding waste of resources and energy); and 6) Equitable (consistent care that does not vary in quality because of race, gender or socioeconomic status).

The IOM report squarely places patient needs at the center of the system, and advocates that changes and actions should be measured not by how they may affect

one or another segments of the industry, but rather by how they affect patients. It emphasizes information technology and advocates shared knowledge, free flow of information among providers, decision support systems and evidence-based decision making, anticipation of needs instead of reaction to events, continuous decrease in waste, and cooperation among clinicians as the norm. It recommends standardization of care for 15 very expensive chronic conditions that include hypertension, diabetes, heart attacks, cholesterol, asthma, cancer, back problems and depression.

It recommends that all members of the health care team become proficient in information technology; that we develop methods to manage the growing medical knowledge base; coordination of care across patient conditions, settings, and time; continuous advancement of team effectiveness; and incorporation of outcome measurements into daily work. It recommends a national commitment and financial support to build a national health information infrastructure, with a goal of eliminating most handwritten clinical data by the end of the decade.

The report is critical of current payment policies and recommends changes in the payment system that will remove barriers to quality, provide fair payment for good clinical management and quality improvement, and alignment of financial incentives with the implementation of processes based on best practices. It recommends modification in the way the government regulates healthcare professionals and changes in the professional liability system.

It recommends that all organizations in the healthcare system should adopt an explicit purpose of improving the health and functioning of the people of the United States, and that all organizations should pursue the six aims for improvement.

I believe this landmark report of the Institute of Medicine has correctly formulated the problem and that it has, more importantly, crafted the plan and the roadmap for durable solutions that will, over time, simultaneously and dramatically improve quality and lower costs.

I believe that the State of Wisconsin should be an early and explicit endorser of the Institute of Medicine report, and that future legislative, regulatory, and funding initiatives should be directed at achieving the six articulated aims, for a 21st century health system that is safe, effective, patient centered, timely, efficient, and equitable.

Thank you for hearing me. I've attached copies of Dr. Hillman's testimony before the Ways and Means Committee, the Executive Summary of the IOM's report, and my remarks on behalf of the Wisconsin Medical Society for your further consideration.

Thank you, again. I am happy to respond to any questions you may have.

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President

Marshfield Clinic